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8	BEFORE THE
9	BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS
10	STATE OF CALIFORNIA
11	In the Matter of the Accusation Against: Case No. 2010-116
12	TAMELIA JEAN LUXON 209 Rock Ford Road ACCUSATION
13	Uriah, Alabama 36480
14	Registered Nurse License No. 569825
15	Respondent.
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17	Louise R. Bailey, M.Ed., RN ("Complainant") alleges:
18	<u>PARTIES</u>
19	1. Complainant brings this Accusation solely in her official capacity as the Interim
20	Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer
21	Affairs.
22	2. On or about August 4, 2000, the Board issued Registered Nurse License Number
23	569825, to Tamelia Jean Luxon ("Respondent"). The registered nurse license was in full force
24	and effect at all times relevant to the charges herein. The license expired on July 31, 2008, and
25	has not been renewed.
26	<u>JURISDICTION</u>
27	3. Business and Professions Code ("Code") section 2750 provides, in pertinent part,
<u> </u>	For the property of the control of t

28 that the Board may discipline any licensee, including a licensee holding a temporary or an

inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

- 5. Code section 2761(a) states, in pertinent part, that the board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for unprofessional conduct.
 - 6. Code section 2762 states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

- (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
- (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

- 8. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M).
 - 9. "Dilaudid," a brand of hydromorphone, is a Schedule II controlled substance as

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FIRST CAUSE FOR DISCIPLINE

(Falsified, Made Incorrect or Inconsistent Entries In Hospital or Patient Records)

Respondent is subject to discipline under Code section 2761(a), on the grounds of 10. unprofessional conduct, as defined in Code section 2762(e), in that between March 9, 2006, and March 20, 2006, while on assignment as a registered nurse at Sierra View District Hospital, located in Porterville, California, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records in the following respects:

Patient "B":

- On or about March 20, 2006, at 0730 hours, Respondent signed out 10 mg. of a. Morphine. Respondent charted the administration of 8 mg. of Morphine, but failed to account for the disposition of the remaining 2 mg. of Morphine in any hospital or patient record.
- On or about March 20, 2006, Respondent signed out 10 mg. of Morphine, but b. failed to account for the disposition of the Morphine in any hospital or patient record. Furthermore, Respondent failed to record the time she signed out the Morphine.
- On or about March 20, 2006, at 1330 hours, Respondent signed out 10 mg. of c. Morphine. Respondent charted the administration of 8 mg. of Morphine, but failed to account for the disposition of the remaining 2 mg. of Morphine in any hospital or patient record.
- d. On or about March 20, 2006, at 1700 hours, Respondent signed out 10 mg. of Morphine, but failed to account for the disposition of the Morphine in any hospital or patient record.

Patient "C":

- On or about March 20, 2006, at 1230 hours, Respondent signed out 2 mg. of e. Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid, but failed to account for the disposition of the remaining 1 mg, of Dilaudid in any hospital or patient record.
- On or about March 20, 2006, at 1600 hours, Respondent signed out 2 mg. of f. Dilaudid. Respondent charted the administration of 1 mg. of Dilaudid, but failed to account for the disposition of the remaining 1 mg. of Dilaudid in any hospital or patient record.

Patient "D":

- g. On or about March 9, 2006, at 0900 hours, Respondent signed out 5 mg. of Morphine. Respondent charted the administration of Morphine, but failed to specify the amount of Morphine administered, and failed to account for the disposition of the Morphine not administered, in that the physician's orders called for 2-4 mg. of Morphine.
- h. On or about March 9, 2006, at 1300 hours, Respondent signed out 5 mg. of Morphine, but failed to account for the disposition of the Morphine in any hospital or patient record.
- i. On or about March 9, 2006, at 1615 hours, Respondent signed out 5 mg. of Morphine, but failed to account for the disposition of the Morphine in any hospital or patient record.
- j. On or about March 10, 2006, at 0830 hours, Respondent signed out 5 mg. of Morphine. Respondent charted the administration of Morphine, but failed to specify the amount of Morphine administered, and failed to account for the disposition of the Morphine not administered, in that the physician's orders called for 2-4 mg. of Morphine.
- k. On or about March 10, 2006, at 1315 hours, Respondent signed out 5 mg. of Morphine. Respondent charted the administration of Morphine, but failed to specify the amount of Morphine administered, and failed to account for the disposition of the Morphine not administered, in that the physician's orders called for 2-4 mg. of Morphine.
- 1. On or about March 10, 2006, at 1600 hours, Respondent signed out 5 mg. of Morphine, but failed to account for the disposition of the Morphine in any hospital or patient record.

SECOND CAUSE FOR DISCIPLINE

(Obtained, Possessed and Self-Administered Controlled Substances)

11. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(a), in that between March 9, 2006, and March 27, 2006, while on assignment as a registered nurse at Sierra View District Hospital, located in Porterville, California, Respondent did the following:

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- Respondent obtained Morphine and Dilaudid, controlled substances, by fraud, a. deceit, misrepresentation or subterfuge or by the concealment of a material fact in violation of Health and Safety Code section 11173(a), by withdrawing the substances for various patients who had not requested the substances and whose medical charts do not disclose pain complaints by the patients when the substances were withdrawn by respondent. Respondent then diverted the withdrawn substances for her own use.
- Respondent possessed Morphine and Dilaudid, controlled substances, in b. violation of Code section 4060, in that Respondent did not have a prescription to possess those controlled substances.
- Respondent self-administered Morphine and Dilaudid, controlled substances, to c. another, without the direction to do so from a licensed physician and surgeon, dentist or podiatrist.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

- Revoking or suspending Registered Nurse License Number 569825, issued to 1. Tamelia Jean Luxon;
- 2. Ordering Tamelia Jean Luxon to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,
 - Taking such other and further action as deemed necessary and proper. 3.

Interim Executive Officer Board of Registered Nursing

Department of Consumer Affairs

State of California

Complainant

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Accusation (kdg) 5/30/09